Child and Youth Services (CYS)

Welcome to Ft Irwin Child and Youth Services

All children and youth must be registered to participate in any CYS program. Central Enrollment is open from 0730 to 1530 Monday thru Friday. The Annual registration fee is $18.00 or $40.00 per family with three or more children.

Please bring the following items with you when you register your child/children:

Childs social security number

2 emergency contacts (other than the parents) that are from Fort Irwin or Barstow

Current Leave and Earning Statement (LES) for the sponsor and pay stub for the spouse if employed

Proof of current immunizations

Power of Attorney if sponsor is unable to come and sign required paperwork

Other possible requirements that may be needed are:

Current sports physical (if registering to play a sport or instructional classes). Please note that physicals are only good for one year and must be current through the sports season.

Infant feeding plan must be completed for infants that are less than 12 months (must be completed prior to placement in a program).

Family Care Plan for sole and dual military parents.

Attend Special Needs Resource Team (SNRT) meeting if child has and allergies, special needs or are part of the Exceptional Family Member Program. The team will evaluate the child prior to them utilizing the program.

Child's birth certificate for children less than 1 year old.

If you have any question please feel free to contact the CER office at 760-380-2257/2258

CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.

PART A

Name of Sponsor	Home Telephone Cell Telephone	Duty/Work Telephone
Sponsor Unit / Work Address	Sponsor SSN	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex
		☐ Male ☐ Female

Does your child have ongoing medical concerns?
(If Yes, explain circumstances and current status)

☐ Yes ☐ No

Is your child enrolled in Exceptional Family Member Program?
(If Yes, explain)

☐ Yes ☐ No

MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Other problems (list below)		
13. Chest pain with exercise					

If you answer yes to any of the above, please explain:

Ongoing Medications

Name	Dosage	Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

PART B: SPORTS PHYSICAL

Medical Staff Assessment (Completed by licensed independent practitioner)

Age YRS MOS	Height _____ cm. (____ %ile)	Weight _____ kgs. (____ %ile)
BP: / P:	Visual Acuity Right / Left / Tested with / without glasses	

	NORMAL	ABNORMAL	N / A	COMMENTS
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia – Hernia				
10. Skin & Lymphatics				
11. Spine – Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No ☐ Normal physical activity to including PE

☐ PA Additional comments: ☐ Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C

Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? ☐ Yes ☐ No

Date	Licensed Health Care Professional Stamp	Licensed Health Care Professional Signature

Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian

Health Assessment Re-Certification

Date	Health Status Changed	Signature of Parent or Guardian
	☐ Yes ☐ No	
Date	Health Status Changed	Signature of Parent or Guardian
	☐ Yes ☐ No	

SPECIAL NEEDS/CHILD PLACEMENT QUESTIONNAIRE

Welcome to Fort Irwin Child and Youth Services programs. If your child should have a special need prior knowledge will allow us to make appropriate adjustments to our program and provide training to the staff.

Child's Name:_____ Date of Birth:_____

Program/Bldg:_____ Today's Date:_____

Does your child/youth have any of the following conditions?

	YES	NO		YES	NO
Developmental delays Explain:			Asthma/Respiratory		
Visual Problems/Blindness (Do not check this box if your child only wears glasses)			Speech/Language Delays		
Hearing Problems (Check this box if our child has had Tubes) Explain:			Allergic Reactions Explain:		
Physical Disability Explain:			Behavioral/Conduct Concerns		
Sickle-Cell Disease (Do not check this box If your child has only the Sickle Cell trait)			Heart Problems		
Kidney Problems Explain:			Diabetes		
Epilepsy/Seizures			Attention Deficit /Hyperactivity (ADD/ADHD)		
Autism			Other (Please specify)		

2. Is your child taking medication for his/her condition If so please specify.

3. Is your child receiving. services from Behavioral Medicine? If yes please explain. Yes No

4. Is your child enrolled in a Developmental Preschool ___Yes ___No

5. Is your child enrolled in the Exceptional Family Member Program ___Yes ___No

_____ _____

Signature of Parent/Guardian **Home and Duty Phone**

_____

Print Name (state rank if applicable)

(OFFICE USE ONLY)

History of Special Need/Medical Condition:

Recommendation: a. Admit/No Significant Modification needed_____ b. Admit w/Care Plan Training date_____ c. Schedule SNRT Date/Time_____

Name of CYS Child and Youth Services program official:_____

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 101-189, Section 1504; E.O. 9397.

PRINCIPAL PURPOSE(S): To collect total family income data to determine child care fees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to furnish information will result in placement in the highest fee range.

SECTION I - DEPENDENT CHILDREN

To determine child care fees for your child(ren), or any child(ren) you legally claim as your dependent(s), you must complete, sign, and return this form to the director of the program you are applying for. Fees will be determined based on your total family income as defined below. If you do not wish to disclose your total family income, your rate will be set automatically at the highest fee level.

1. NAME OF EACH CHILD *(LAST, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. AGE	4. CARE REQUESTED
a.			
b.			
c.			
d.			
e.			

SECTION II - ANNUAL FAMILY INCOME *(To be completed by sponsor. Include all military and civilian earned income for sponsor and spouse.)*

Enter your annual income data as requested; e.g., multiply the most recent monthly income by 12 or if paid on a biweekly income, enter the most recent biweekly income and multiply by 26. For purpose of determining child care fees in DoD Child Care program, total family income is defined as all earned income including wages, salaries, tips, long-term disability benefits, combat pay and voluntary salary deferrals. Include all earned income such as wages, salaries, tips, long-term disability benefits, voluntary salary deferrals, retirement or other pension income, etc., before deductions for taxes, social security, etc. Include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind. For dual military living in government quarters include BAH-II of senior member only. Include anything else of value, even if not taxable, that was received for providing services. DO NOT INCLUDE cost of living allowance (COLA) received in high cost areas, alimony and child support, temporary duty allowances or reimbursements for educational expenses.

5. SPONSOR

a. NAME *(LAST, First, Middle Initial)*	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE

d. INCOME

(1) BASE PAY *(Most recent leave and earnings statement)*	(2) BASIC ALLOWANCE FOR HOUSING *(Or in-kind equivalent) (Annual chart of minimum BAH-II)*	(3) BASIC SUBSISTENCE ALLOWANCE *(Or in-kind equivalent)*	(4) OTHER EARNED INCOME AS DESCRIBED ABOVE

6. SPOUSE

a. NAME *(LAST, First, Middle Initial)*	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE

d. INCOME

7. OTHER EARNED INCOME AS DESCRIBED ABOVE	8. TOTAL INCOME FOR SPONSOR, SPOUSE, AND OTHER

SECTION III - CERTIFICATION OF SPONSOR *(Required for Category I - IV. Please read the following statement carefully before signing.)*

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application; and that deliberate misrepresentation of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR*	10. SIGNATURE OF SPOUSE	11. DATE SIGNED *(YYYYMMDD)*

**If signature is missing, the fees will automatically be placed at the highest level.*

12. TELEPHONE NUMBERS *(Include Area Code)*		13. HOME ADDRESS *(List apartment number and 9-digit ZIP Code)*
a. HOME	b. WORK	
(1) SPONSOR		
(2) SPOUSE		

SECTION IV - FOR CHILD DEVELOPMENT CENTER USE ONLY

14. CATEGORY OF APPROVAL	15. AUTHORIZED FEES
16. DATE OF APPROVAL *(YYYYMMDD)*	17. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

Child and Youth Services (CYS) Patron Fees
Effective 1 Nov 2006

Non-refundable Registration Fee: $16 - 1st child/youth; $18 - 2nd child/youth; or $40 per year for 3+ child/youth.

Income Category	I	II	III	IV	V	VI
	$0-28,000	$28,001-34,000	$34,001-44,000	$44,001-55,000	$55,001-70,000	$70,001 and higher
CDC Full Day Semi-monthly Fees *						
1st child	98	152	181	216	245	272
2nd child	88	137	163	194	220	245
CDC Before or After Kindergarten Semi-monthly Fees*						
1st child	23	55	65	78	87	97
2nd child	21	50	59	70	78	87
CDC Before and After Kindergarten Semi-monthly Fees*						
1st child	39	94	111	134	153	174
2nd child	35	85	100	121	138	157
CDC Play and Learn Monthly Fees**						
2 Day Program: 1st child	32	48	58	70	79	90
2nd child	29	43	52	63	71	81
3 Day Program: 1st child	49	74	87	104	119	135
2nd child	43	67	78	94	107	121
5 Day Program: 1st child	81	122	145	174	198	225
2nd child	73	95	130	157	178	202
CDC Hourly Care* **						
CDC: $4.00 per hour per child/ Category I patrons $2.50 per hour						

School Age Services (SAS)						
Before or After Grade (1st-5th) Semi-monthly Fee*						
1st youth	23	55	65	78	87	97
2nd youth	21	50	59	70	78	87
Before and After Grade (1st-5th) Semi-monthly Fee*						
1st youth	39	94	111	134	153	174
2nd youth	35	85	100	121	138	157
Kindergarten and SAS Summer Camp Weekly Fee*** **						
1st youth	35	54	64	77	87	98
2nd youth	32	49	58	69	78	88

SAS/Kinder Hourly****
SAS/Kinder $3.00 per hour per youth/Category I patrons $2.00 per hour

Middle School Summer Extended Hours Weekly Fee*****						
1st youth	10	17	19	22	25	28
2nd youth	9	15	17	20	22	25

Youth Sports					
Sport	Soccer	Flag Football	Baseball	Basket-ball	Roller Hockey
1st youth	35	35	45	45	65
2nd, 3rd, etc. per child	28	28	34	34	52
Coach's first youth at no cost; additional youth in same sport at 50% of fee. Late registration fee $10 per youth per sport.					

*SEMI-MONTHLY FEES are due the 1st and 16th of each month. A $5.00 late fee per child will be assessed COB the 3rd business day. Your child will not be accepted in CDC or SAS until fees are paid in full.

**MONTHLY FEES are due on the first class attendance day of each month. A $5.00 late fee will be after the second class attendance day of the month.

***Minimum rate is one hour with quarter hour charges following the first hour. One quarter hour is $1.00/$.65.

****Minimum rate is one hour with quarter hour charges following the first hour. One quarter hour is $.75/$.50. $5.00 cancellation fee per child for failure to cancel one hour in advance. CDC hourly closed during MAX leave periods.

*****WEEKLY FEES are due the Friday before the following Monday session. A $5.00 late fee will be charged Monday morning.

LATE PICK UP FEE: $1.00 per minute starting at 1730 for full day CDC/Kinder/SAS; 1100/1530 for part day toddler/preschool programs; 1430 for CDC hourly care. There is NO grace period for pick up.

VACATION POLICY: All full day CDC and SAS children may have 2 weeks fees subtracted from the semi-monthly fee per fiscal year. **Hourly and PAL children are not eligible for vacation.**

PAL program is closed during MAX leave period with no change to the monthly fee. Monthly PAL fees have been computed with Christmas max leave at no charge.

LETTER TO PARENTS
(Non-Pricing Program)

Dear Parents:

We receive meal reimbursement from the Child and Adult Care Food Program (CACFP) offered by the United States Department of Agriculture (USDA). With this assistance, we are able to maintain reasonable child care fees while providing nutritious meals. To enable us to continue this reimbursement assistance please complete, sign, and return the enclosed Center Eligibility Application. If your first language is not English, you have the right to ask us for written or oral translation or oral translation of materials free of charge in your native language. The information will only be used to determine the eligibility category of your child(ren) and verification of data.

You may provide information using household size and income, receipt of food stamps, California Work Opportunity and Responsibility to Kids (CalWORKSs), Food Distribution Program on Indian Reservation (FDPIR), or Kinship Guardian Assistance Payment (Kin-GAP) Program. If you have foster children, please contact us for special instructions.

If your household income is from seasonal or part-time sources, you may report the total monthly income or the amount you received for the past 12 months; whichever better indicates the financial circumstance of your household.

You may report loss of employment or income that your household may experience. This information may allow us to begin receiving meal reimbursements for your child.

During anytime of the year, a CACFP representative may verify your eligibility information. Deliberate misrepresentation of information may be subject to prosecution under applicable state and federal laws.

Please contact the child care center if you do not agree with the determination of your child(ren)'s eligibility. If you wish to review the decision further, you have the right to a fair hearing. You may request a hearing by contacting:

Jana Trouberman at (760) 380-4830, Bldg 1323, Fort Irwin, CA 92310

ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the *Child and Adult Care Food Program Center Eligibility Application* using the instructions below. Sign the application and return it to the sponsor. Call the sponsor if you need help:

PART I - PARTICIPANT'S INFORMATION: ALL HOUSEHOLDS **MUST** COMPLETE THIS PART.
Print the names of children enrolled in the center. (Mark (X) box if this is a foster child. List only one foster child per form.)

PART 2A - HOUSEHOLDS RECEIVING FOOD STAMPS, CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY FOR KIDS (CalWORKs), KINSHIP GUARDIAN ASSISTANCE PAYMENTS PROGRAM (Kin-GAP) OR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR) BENEFITS: COMPLETE PART 2A AND PART 3.

(1) List your current Food Stamps case number or your CalWORKs, Kin-GAP or FDPIR identification number for the participant. Do not complete Part 2B.
(2) An adult household member must sign the statement in Part 3.

PART 2B - ALL OTHER HOUSEHOLDS: COMPLETE PART 2B AND PART 3.

(1) Write the names of everyone in your household, except children listed in Part 1.
(2) Write the amount of income (before taxes or anything else is taken out), received last month for each household member, and where it came from, such as earnings, welfare, pensions, and other income (refer to examples below for types of income to report). If any amount last month was more or less than usual, write that person's usual income.
(3) *Parent/guardian or another adult household member must sign and give his/her social security number in Part 3.

PART 2C - FOSTER CHILD: COMPLETE PART 2C AND PART 3 FOR EACH FOSTER CHILD LIVING IN YOUR HOME AND ENROLLED FOR CARE.

PART 3 - SIGNATURE AND SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART.

(1) All Center Eligibility Applications must have the signature of an adult household member.
(2) The adult household member who signs the statement must include his/her social security number. If he/she does not have a social security number, mark (X) box. If you listed a food stamp, CalWORKs, FDPIR, or Kin-GAP number or if the application is for a foster child, a social security number is not needed.

*Section 9 of the National School Lunch Act requires that, unless the participant's Food Stamp, CalWORKs, FDPIR, or Kin-GAP information is provided, you must include the social security number of the adult household member signing the application or an indication that the household member signing the application does not have a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the application does not have a number, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations, and may include contacting employers to determine income, benefits, contacting the State's Employment Development Department offices to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported."

PART 4 - RACIAL/ETHNIC IDENTITY: IDENTIFICATION OF CHILDREN IS VOLUNTARY.
You are not required to complete this section to receive meal benefits. However, this information will help ensure that every person is treated fairly.

PART 5 – FOR SPONSOR USE ONLY: It is the sponsor's responsibility to complete PART 5.

INCOME TO REPORT

Earnings from Employment

Wages/salaries/tip, strike benefits, unemployment compensation, worker's compensation, net income from self-owned business, day care, farm, or other.

Welfare/Child Support/Alimony

Public assistance payments, welfare payments, alimony/child support payments.

Foster Child's Income

ONLY funds from welfare agency identified by category for personal use of child (clothing, school fees, etc.), funds from child's family for personal use and earning from other than occasional or part-time employment. DO NO COUNT funds from welfare agency for shelter, care, etc.

Pensions/Retirement/Social Security

Pensions, retirement income, veteran's payments, social security, **Supplemental Security Income ($10.00 may be deducted from SSI check amounts as the Food Stamp equivalency).*

Military Households

All cash income, including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)

Other Income

Disability benefits, cash withdrawn from savings, interest/dividends, income from trusts/investments, regular contributions from persons not living in household, net royalties/annuities/net rental income, or any other income.

CHILD AND ADULT CARE FOOD PROGRAM

CENTER ELIGIBILITY APPLICATION

(INSTRUCTIONS ON BACK)

PART 1 – FOR ALL HOUSEHOLDS: ***LIST ONLY ONE FOSTER CHILD PER APPLICATION FORM***

PARTICIPANT'S LAST NAME	FIRST NAME	M. I.	AGE	BIRTH DATE	MARK (X) BOX IF FOSTER CHILD
					☐
PARTICIPANT'S LAST NAME	FIRST NAME	M. I.	AGE	BIRTH DATE	☐
PARTICIPANT'S LAST NAME	FIRST NAME	M. I.	AGE	BIRTH DATE	☐
PARTICIPANT'S LAST NAME	FIRST NAME	M. I.	AGE	BIRTH DATE	☐

PART 2A – FOR HOUSEHOLDS RECEIVING FOOD STAMPS, CalWORKs, FDPIR, or Kin-GAP BENEFITS: Complete Part 2A and Part 3. DO NOT COMPLETE PART 2B.

FOOD STAMP CASE NUMBER	CALWORKS IDENTIFICATION NUMBER
FDPIR IDENTIFICATION NUMBER	KIN-GAP IDENTIFICATION NUMBER

PART 2B – ALL OTHER HOUSEHOLDS: If you did not complete Part 2A, complete Part 2B and Part 3.

NAMES OF ALL HOUSEHOLD MEMBERS (DO NOT INCLUDE CHILDREN LISTED ABOVE.)	INCOME BY (CHECK APPROPRIATE BOX)	LIST SOURCES OF INCOME (SEE BACK PAGE)
1.	$ ☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY ☐ ANNUAL	
2.	$ ☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY ☐ ANNUAL	
3.	$ ☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY ☐ ANNUAL	
4.	$ ☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY ☐ ANNUAL	
5.	$ ☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY ☐ ANNUAL	
6.	$ ☐ WEEKLY ☐ EVERY 2 WEEKS ☐ TWICE A MONTH ☐ MONTHLY ☐ ANNUAL	

PART 2C – FOSTER CHILD: Complete Part 2C and Part 3. ***LIST ONLY ONE FOSTER CHILD PER APPLICATION FORM (NSD 3101)***

Foster child's total monthly income: $

PART 3 – SIGNATURE: ***An adult household member must sign the statement before it can be approved.***

PENALTIES FOR MISREPRESENTATION: *I certify that all of the above information is true and correct and that the food stamp, CalWORKs, FDPIR, or Kin-GAP number is correct or that all income is reported. I understand that this information is being given for the receipt of federal funds, that institution officials may verify the information on the statement, and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.*

SIGNATURE OF ADULT	PRINTED NAME OF ADULT	
SOCIAL SECURITY NUMBER	If no Social Security Number, mark (X) box ☐	DATE SIGNED
HOME ADDRESS	ZIP CODE	HOME TELEPHONE NUMBER / WORK TELEPHONE NUMBER

PART 4 – RACIAL IDENTITY: ***(Identification of children is voluntary):***

American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	ETHNIC IDENTITY Mark (X) box if this participant is Hispanic or Latino
☐	☐	☐	☐	☐	☐

PART 5 – FOR SPONSOR USE ONLY: Monthly Income Conversion

CERTIFICATION

Total household Income: _____ Weekly ☐ Every Two Weeks ☐ Twice Per Month ☐ Monthly ☐ Annual ☐

Household size: _____ Eligibility Category: Free ☐ Reduced-Price ☐ Base ☐

SPONSOR REPRESENTATIVE SIGNATURE	DATE

Re-certification Date: Free ☐ Reduced-Price ☐ Base ☐

Re-certify only with the issuance of a new eligibility scale or with the reporting of updated eligibility information. Applications are valid for 12 months from the original certification date, not the new re-certification date.

Daycare Parent Sample of Signature & Initials

Our Internal Review Auditor has recently required the USDA Child and Adult Care Food Program (CACFP) to obtain a sample signature and initial of parents upon enrollment in Child Development Services. Please take a moment to help us satisfy this request.

Name of children: _____

_____

_____

_____

☐ Yes ☐ No Are you a Single Parent? Please check Yes or No.

	Signatures	Initials
Father		
Mother		
Other		

Thank you for helping the USDA Child and Adult Care Food Program insure integrity on attendance forms in Family Child Care (FCC) homes and Child Development Centers (CDC).

Please call the USDA CACFP office at 380-4830 if you have any questions.